1971 WHITE HOUSE CONFERENCE ON AGING

Special Concerns Session

Aging and Blindness

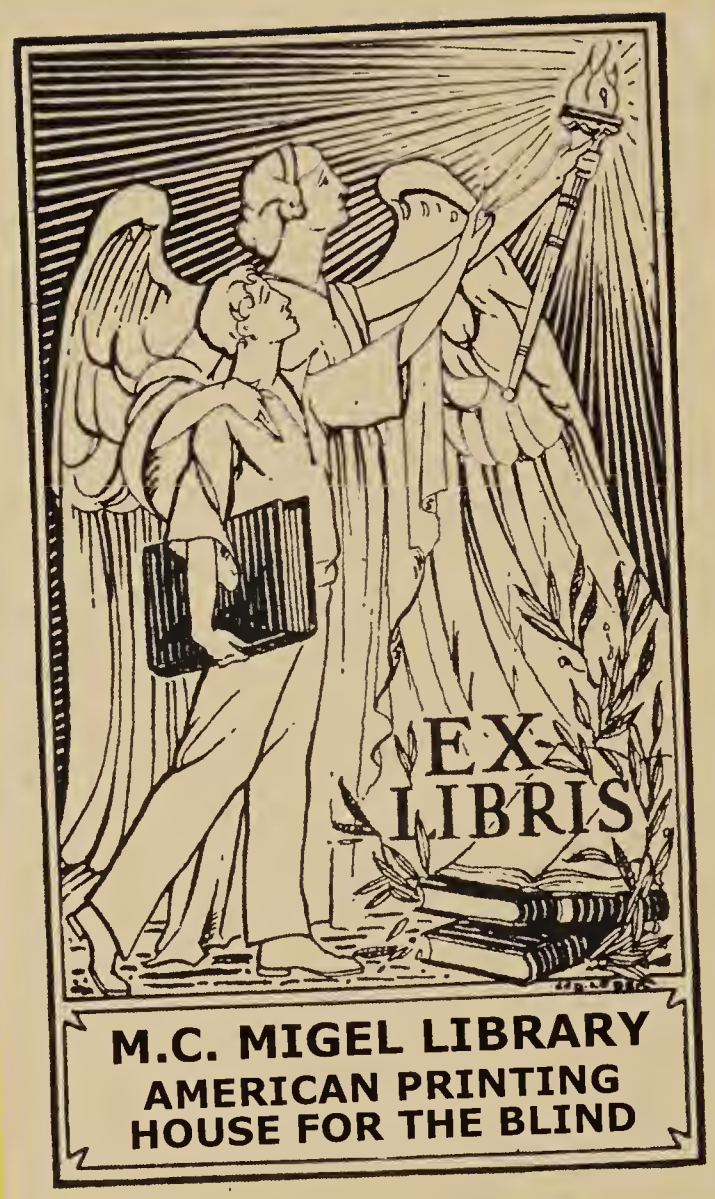
December 1, 1971

Washington, D.C.

A Report to the National Task Force on Geriatric Blindness

Text of major Speeches and Recommendations made during the Session.

AMERICAN FOUNDATION FOR THE BLIND, INC.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WHITE HOUSE CONFERENCE ON AGING, 1971

RECOMMENDATIONS

SESSION ON SPECIAL CONCERNS

AGING AND BLINDNESS

Introduction

Since the American Foundation for the Blind participated actively in the 1961 White House Conference on Aging, we have a deep appreciation of its constructive impact in generating increased public awareness and concern for the unmet needs of our aging population and in stimulating a larger use of our nation's resources in meeting these needs.

We, in collaboration with other national, state and local organizations of and for the blind, do appreciate an opportunity to share with you our special concerns. As reported by the National Society for the prevention of Blindness, approximately half of the estimated 500,000 legally blind persons in the United States are 65 years of age or older while two thirds are past middle age. Moreover, the majority of all new cases of blindness each year fall within the same age bracket. Despite these facts, most of our efforts, in both the governmental and private sectors, have been directed to blind children and to blind adults of employable age. Only recently have we begun to consider the needs of the older blind person.

Another aspect of our special concern stems from our philosophical belief in the desirability of helping blind persons to achieve their fullest potential as integrated members of their community. While this belief in no way contradicts the need for specialized and often separate services for persons who are visually handicapped, there is an equal need to insure the availability of general community services. Within this context, our hope is that blind persons -- in fact all handicapped individuals -- will become beneficiaries of the rapidly expanding programs and services for older persons in such fields as health, nutrition, housing, recreation, employment, continuing education, etc. It often takes little if any adaptation to implement this concept, but unfortunately it rarely occurs automatically, i. e., without continuing interpreatation, education and planning.

In summary, we urge that the 1971 White House Conference give a high priority to the question of how handicapped persons, especially those who are visually handicapped, can be more effectively integrated and served by the ever-increasing number of special programs for older persons. As Senator Jennings Randolph of West Virginia stated in his keynote address to the Special Concerns Session on Aging and Blindness, "It is clear that we must change attitudes toward the blind. We must provide opportunities for normal living in society; not charity, but a chance. I fear that there is widespread misconception about the abilities and aspirations of elderly blind persons."

Our specific recommendations follow:

Recommendation

1. It is recommended that Congress increase old age, survivors and disability insurance and the adult public assistance categories to the intermediate level of living recommended by the Bureau of Labor Statistics (at least $2,297 for a single person and $4,185 for a married couple) and further that the adult categories of public assistance be federalized and that Social Security benefits not be deducted from public assistance payments.

Recommendation

2. It is recommended that the National Eye Institute and other interested organizations on a national and local level combine their efforts in an urgent overall program to prevent or alleviate diabetic retinopathy; establish a center for the study of diseases of the macula, and increase research efforts in the fields of cataract, glaucoma and vascular diseases of the eye; establish screening efforts especially at hospitals, medical centers, homes for the aged, nursing homes, and extended care facilities to find aged patients who have blinding eye diseases which can be helped by medical or surgical means and low vision aids. Such efforts should be made by interested philanthropic organizations and implemented if necessary by legislative action;

It is further recommended that the National Eye Institute be required to develop better statistics on incidence, prevalence and etiology of blinding eye conditions: that Congress amend Titles XVIII and XIX of the Social Security Act to cover low vision aids when the need is certified by an ophthalmologist or an optometrist specializing in low vision treatment; and that the number of low vision centers be increased and that the centers be staffed under the supervision of an opthalmologist or a qualified optometrist.

Recommendation

3. It is recommended that the Vocational Rehabilitation Act be broadened to make rehabilitation services available to blind persons without regard to age or economic need and that Congress be urged to enact S.1030, a bill to amend the Vocational Rehabilitation Act to provide rehabilitation services for older blind persons, and S.2506, a bill to amend the Randolph-Sheppard Act, to accomplish these purposes.

Recommendation

4. It is recommended that the elderly, including the blind and handicapped, must have access to all modes of mobility and transportation for obtaining the essentials of daily living and the cultural and social benefits of modern society.

Recommendation

5. It is recommended that the Administration and Congress develop a network of personal care benefits for individuals with a certain level of functional disability to enable the older person to purchase whatever services are necessary to help him remain in his own home if he so wishes; such benefit is to be in addition to basic minimum income and assure a financial basis for local community service providers.

CONTENTS

WHITE HOUSE CONFERENCE ON AGING

SESSION ON SPECIAL CONCERNS

SPONSORED BY THE AMERICAN FOUNDATION FOR THE BLIND, INC. AND THE NATIONAL TASK FORCE ON GERIATRIC BLINDNESS

Washington Hilton Hotel, Washington, D.C.
Wednesday, December 1, 1971
8:00 A.M. - 12:00 Noon

TOWARD A NATIONAL POLICY ON AGING AND BLINDNESS

Presiding: Garson Meyer, Co-Chairman
National Task Force on Geriatric Blindness

8:00 A.M. - Opening Remarks

- American Foundation for the Blind, Inc., New York
  Dr. Peter J. Salmon, Trustee

- National Task Force on Geriatric Blindness - AFB
  Dr. Robert Morris - Garson Meyer, Co-Chairmen

- National Society for the Prevention of Blindness, Inc., New York
  Dr. Wilfred D. David, Executive Director

- National Eye Institute, Bethesda, Maryland
  Dr. Robert A. Resnik, Chief, Office of Program Planning

8:30 A.M. - Speaker
Senator Jennings Randolph of West Virginia
Special Committee on Aging, U. S. Senate

9:00 A.M. - Panel: Policy and Platform Statements
in behalf of the elderly blind population in U.S.A.

- Income Maintenance
  Dr. Juanita M. Kreps, Professor of Economics and Dean,
  The Woman's College, Duke University, Durham, North Carolina

- Medicine and Health
  Dr. A. L. Kornzweig, Chairman, Liaison Committee
  AFB - American Geriatrics Society, New York

- Rehabilitation
  Dr. Douglas C. MacFarland, Director, Office for the Blind
  and Visually Handicapped,
  Social and Rehabilitation Service, -D/HEW, Washington, D.C.

- Transportation
  William C. Fitch, Executive Director
  The National Council on The Aging
  Washington, D. C.

- Home Help Service
  Dr. Robert Morris, Director
  Max Levinson Gerontological Policy Institute
  Professor of Social Planning
  The Florence Heller Graduate School for Advanced Studie in Social Welfare
  Brandeis University, Waltham, Massachusetts

- Coffee Break at discretion of chairman

10:40 A.M. - Discussion on policy recommendations

* An invited group of elderly blind persons and special personnel will serve as reactors during this period.

11:00 A.M. - Adoption of policy and platform statements by floor vot for final recommendations in the White House Conference Report.

12:00 Noon - Adjournment

*

William Edwards
Columbia Lighthouse for the Blind
Washington, D. C.

Aparicio G. Ranghel
Washington, D. C.

John F. Nagle, Chief, Washington Office
National Federation of the Blind, Inc.
Washington, D. C.

Durward K. McDaniel, National Representative
American Council of the Blind, Inc.
Washington, D. C.

American Foundation for the Blind, Inc.
Session on Special Concerns - WHCA

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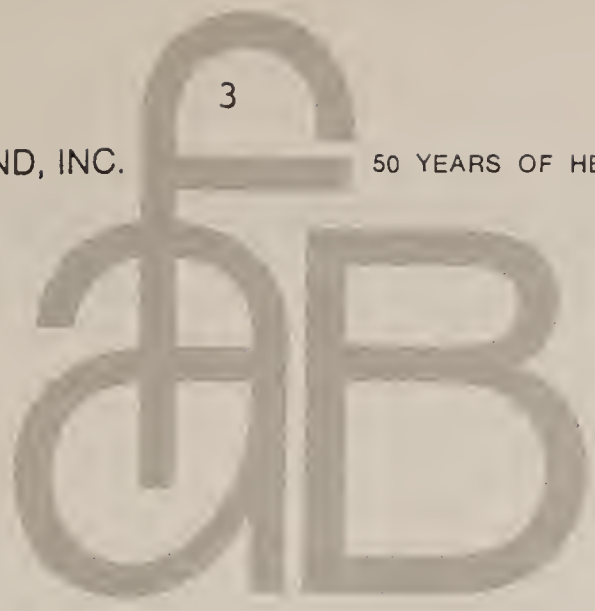

50 YEARS OF HELPING BLIND PEOPLE BECOME JUST PEOPLE

WHITE HOUSE CONFERENCE ON AGING, 1971

A Position Statement*

Since the American Foundation for the Blind participated actively in the 1961 White House Conference on Aging we have a deep appreciation of its constructive impact in generating increased public awareness and concern for the unmet needs of our aging population and in stimulating a larger use of our nation's resources in meeting these needs.

We do appreciate an opportunity to share with you our special concerns. As reported by the National Society for the Prevention of Blindness, approximately half of the estimated 400,000 legally blind persons in the United States are 65 years of age or older. Moreover, the majority of all new cases of blindness each year fall within the same age bracket. Despite these facts, most of our efforts, in both the governmental and private sectors, have been directed to blind children and to blind adults of employable age. Only recently have we begun to consider the needs of the older blind person.

Another aspect of our special concern stems from our philosophical belief in the desirability of helping blind persons to achieve their fullest potential as integrated members of their community. While this belief in no way contradicts the need for specialized and often separate services for persons who are visually handicapped, there is an equal need to insure the availability of general community services. For example, in the field of special education, while many visually handicapped children are found in special residential schools and quite properly so, today more than half are enrolled in local public schools. Within this context, our hope is that blind persons -- in fact all handicapped individuals -- will become beneficiaries of the rapidly expanding programs and services for older persons in such fields as health, nutrition, housing, recreation, employment, continuing education, etc. It often takes little if any adaptation to implement this concept, but unfortunately it rarely occurs automatically, i.e. without continuing interpretation, education and planning.

In summary, we urge that in planning for the 1971 White House Conference a high priority be given to the question of how handicapped persons, especially those who are visually handicapped, can be more effectively integrated and served by the ever-increasing number of special progra for older persons.

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* Prepared by National Task Force on Geriatric Blindness, April, 1971.

National Society for the Prevention of Blindness, Inc.
79 Madison Avenue, New York, N.Y.10016 212/684-3505

Executive Director:
Wilfred D. David, M.D., M.P.H

August 2, 1971

* Statement on prevention and treatment of blindness

"I am writing you on behalf of the National Society for the Prevention of Blindness, Inc. to urge that the 1971 White House Conference on Aging seriously consider support of the policy proposal of the Health Committee of the Conference 'Among the complex (health) needs for the aged, priority should be given to the prevention and treatment of blindness.'

Attention must be directed to the prevention and treatment of blindness since it is estimated that close to 50% of the legally blind are 65 years of age or over. Since half of all blindness could have been prevented, with the application of present knowledge, prevention must be emphasized.

The National Society for the Prevention of Blindness estimates that for 1970 there were a total of 437,000 cases of legal blindness in the United States and in 1970 some 34,000 new cases occurred. The Society's projected estimates for 1977 indicate that there will be close to 500,000 cases of legal blindness in the United States with about 39,000 new cases occurring during 1977. It is expected that the increase in blindness will continue to parallel the increase in total population.

It should be of particular concern that in 1977, the projected prevalence of blindness for the 40-64 age group will be 248.7 per 100,000 population; this figure increases to 1123.9 per 100,000 population for the 65 and over age group. The estimated blindness incidence rates for 1977 will also increase significantly in the older person with a rate of 1719 per 100,000 population in the 40-64 age group, as compared with 94.0 per 100,000 population in the 65 and over age group.

Among the leading causes of blindness among the older person are senile cataract, glaucoma, diabetes, vascular diseases (and macular degenerations). Senile cataract is the largest single known cause of blindness in the older persons and in over 95% of the uncomplicated causes, the condition is successfully treated with surgery. In the case of glaucoma early detection and prompt medical treatment will result in preventing further visual loss and blindness in most cases. Intensified public information and professional education programs about the importance of early detection and treatment in preventing blindness from cataract and glaucoma are essential. In the case of blindness from diabetes (diabetic retinopathy) and vascular diseases, priority support for dissemination of the results of eye research is urged. Also urgently needed is

strong professional and public education on the importance of early and regular eye care with the treatment of diabetes. Safety information will help prevent or reduce the many needless blinding accidents.

The National Society and its affiliates are interested in working with the Conference toward the action goal of improvement of the quality of living for our 20 million older persons."

* With the permission of Dr. Wilfred D. David, Executive Director of National Society for the Prevention of Blindness, Inc. This is taken from a letter sent by Dr. David to Chairman of White House Conference on Aging, August, 1971.

AFB
DD/hb

THE 'NOW GENERATION* IS HERE;
THE NEEDS OF THE GENERATION ARE NOW--
MUST BE MET NOW

* Senator Jennings Randolph

I welcome the opportunity to participate in this Session on Special Concerns of the White House Conference on Aging. Yours is a special mission that combines two personal and important concerns for me.

This morning you will hear detailed discussion from this panel of experts in the areas of income maintenance, medicine and health, rehabilitation, transportation and home help service. Out of this important session hopefully will come policy recommendations which will -- firmly and forcefully - imbed in the public conscience the need for a national policy on aging and blindness.

Tragically, the two words -- aging and blindness -- are becoming too synonymous. We know, for example, that unless greater prevention and treatment methods are prescribed and administered promptly, the increase in blindness will continue to parallel the increase in total population. And we know that half of the new cases of blindness will occur among persons age 65 years or older.

My role in this conference is a difficult one. It would be bootless for me to attempt to convey to you the magnitude of this growing problem, or the urgency of a national policy to try to alleviate it. You live the situation. At the same time, I cannot claim the special focus of expertise that our panelists possess.

So I confine my remarks this morning to a more generalized approach to the many facets of a largely unrecognized or studiously ignored national problem.

You may have heard about the little boy sitting on the curb beside the school playground. He was crying. An elderly gentleman out for a stroll stopped to comfort him. When asked the source of his unhappiness, the little boy pointed to the playground, where several larger boys were laughing and shouting, and the little boy said: "They say I'm too little to play with them. They say I can't run or jump or hit a ball good enough. They're having a good time -- but what about me?"

The gentleman sensed this youngster's frustration, and began a comforting discourse on the problems of yough.

He concluded with: "Soon you will grow as big as they are .. and then you'll be strong and tall and able to run and jump and hit a ball with the bigger boys."

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* The Honorable Jennings Randolph, West Virginia
Member, Special Committee on Aging, U. S. Senate

With these words, the little boy dried his tears and, with a look of pleased revelation, skipped down the street.

At that point, the elderly man who had been reassuring his young friend sat down on the curb and sobbed:

"Yes, but what about me?"

There is, I feel, a parable in this story which could be applied to the consensus on national needs and priorities. Over the past several months, the Senate Committee on Labor and Public Welfare, on which I serve as the senior majority member, has been deeply involved in major legislation concerning areas of education, child care, job opportunities and similar national concerns.

During this same period, our Special Committee on Aging has conducted a considerable number of hearings, studies, consultations and investigations on our aging population. I'm sure that many of you already are familiar with the basic conclusions of the pre-Conference report of the Aging Committee, I express neither shock nor surprise at the conclusions of this report.

Yet, the stark statistical evidence that nearly five million of our elderly citizens live below the proverty level is difficult to accept. The finding that the economic problems of old age are growing-- not decreasing-- and that a new class of impoverished citizens between ages 60 and 64 has developed; these are matters this conference can and must take steps to resolve.

Somewhere along the line, we've gotten our tenses mixed. We are told that the future belongs to youth, and we can accept that. But if there is a "Now" generation -- as Madison Avenue copywriters contend -- it is not the young in America.... it is the 20 million or more Americans who have worked out their productive years, paid their taxes and raised their children. The "now Generation" is HERE, and its needs are now.

The dreadful combination of shortfalls in expected retirement income and cruelly rising inflation has cast millions of elderly Americans adrift on an economic ice floe.

We are a humane people; a great nation of practically limitless resources and ability to provide for the less fortunate.

Yet, the order of priorities in our society is too often determined by noise, rather than need.

It is the task of this conference to awaken our country to the problems of health, isolation, housing, transportation and nutrition among our older Americans. It is the task of Congress and the Administration to correct the injustices attending old age, to the extent possible.

The most frequently heard phrase of this conference is: "It's tough to be old." But in the words of my good friend, Irv Schloss, it is "even tougher to be old and blind."

You are aware of my particular concern for employment opportunities and rehabilitation services for the blind. Over the years, public and private agencies serving blind persons have tended to emphasize educational and related services for the young; and income maintenance for blind and blinded adults for whom employment cannot be found.

At the same time, our steadily increasing lifespan, health advances, and changing population patterns have resulted in older persons becoming the largest single group in the blind population. The need of these persons for adequate basic rehabilitation services to alleviate the handicapping effects of blindness has now become critical.

It is my belief that the most effective way of meeting this critical need of older blind persons will be in providing Federal financial assistance, channeled through appropriate State and local agencies. Then, too, there are institutions of higher education, to provide direct services, train specialized personnel, and conduct research and demonstration projects.

Last March, I introduced legislation which would, I believe, be a major step toward accomplishing these goals. I join with the American Foundation for the Blind and other national organizations in the belief that one of our greatest national potentials is lost when we fail to utilize the abilities of our blind and severely handicapped persons.

It is clear that we must change attitudes toward the blind. We must provide opportunities for normal living in society; not charity, but a chance. I fear that there is widespread misconception about the abilities and aspirations of elderly blind persons.

I have received numerous letters in opposition to a bill I introduced to amend the Randolph-Sheppard Act. Almost invariably, they are prefaced with the sentence, "I have nothing against the blind, but ..." The proposed Randolph-Sheppard Amendments would, among other things, provide for exclusive assignment of revenues from vending machines in federal installations to the Randolph-Sheppard program for blind vendors. Today, as you know, the program is constricted because much of the revenues from these machines are going to federal employee recreation and welfare clubs.

Perhaps the most innocently cruel thought in connection with this provision came from the wife of a federal employee, who wrote: "let the welfare take care of these people. Don't take away our recreation funds!"

I submit that it is this attitude -- and I hope it is not as prevalent as is indicated -- that can and must be changed.

This historic conference -- only the second in our nation's history -- can be the benchmark for sweeping change in our national purpose. Let us hope that out of the millions of words written and spoken during and after this event, there will emerge specific proposals for the Federal-State policies and programs you will discuss today.

I pledge you my unreserved efforts toward that end.

THE AGED BLIND: THE INCOME MAINTENANCE ISSUES

* Juanita Kreps, Ph.D.

The National Task Force on Geriatric Blindness recently declared that

> The primary objective of all governmental and voluntary agency programs shall be to assure all blind and other severely handicapped persons the opportunity to live in and to maintain their own homes.

There is probably no disagreement with that goal. Nor is there with the policy statement of the American Foundation for the Blind, which has held that

1. Full or meaningful employment in industry, business, or the professions, with competitive compensation, should be the goal of all blind persons.

2. There should be developed a national plan for adequate income maintenance for all persons who have special needs because of blindness or other impairments and whose security cannot be assured through full employment or social insurance.

3. Pending the achievement of numbers 1 and 2, there should be established a national minimum standard of public assistance below which no state may fall.

4. The declaration method for determining eligibility for public assistance should be adopted in the interest of preserving the sense of dignity and selfworth of blind recipients.

Against these goals, our task is then to examine how far we are short of achievement, and what proposals we can make to bring the needed improvements.

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* Professor of Economics, Dean,
The Woman's College of Duke University.

In any review of the economic status of the aged blind, certain facts stand out. A recent report[1] indicated that

> -- at present, there are about 215,000 blind persons 65 years of age or older;
>
> -- by 1985, this number will more than double, to an expected 474,000;
>
> -- a total of 80,700 blind persons are now receiving public assistance; the median age of the recipients is 61.3 years, and about 40 percent of them are aged 65 or over.

Other studies have attempted to quantify the amounts of income the blind receive from different sources, and to examine the special needs of blind persons which result in extra living expenses. Neither side of this coin has been adequately examined, however, and one is left with some observations which, although not yet researched, are nevertheless persuasive.

From a 1968 Conference on Geriatric Blindness:[2]

> It is a well-established fact that the blind and visually limited are among the poorest in the country. It is useless to discuss ancillary benefits, even health care, unless we are willing to face the difficult solution of proper income maintenance. At least 25 percent of all severely visually impaired persons in this country are receiving some form of public assistance. If you add to this the number of individuals who are dependent on their families, or whose retirement or social security benefits are inadequate for their needs, the problem assumes pathetic proportions. Some of the persons in this group we are discussing can solve this problem through employment, but for the large majority the only solution is a guaranteed minimum income that is developed realistically in accordance with need, and contains provisions for automatic adjustments to the cost of living.

What has been done since then, or even proposed, to alleviate the income stress of such groups? Very little has actually been done. Social Security benefits have shown some rise, but hardly enough to offset increases in living costs. Welfare payments remain uneven, state by state. Certainly there has been no improvement in job

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1 Barbara C. Coughlan, "Future Directions of Government Programs," The New OUTLOOK for the Blind (Volume 65, Sept. 1971),pp.215-217.

2 Proceedings of the Research Conference on Geriatric Blindness and Severe Visual Impairment, American Foundation for the Blind, May, 1968, p. 55.

opportunities for this group; it is doubtful that even a return to a tight labor market would bring with it any improvements in the earnings of the blind, much less the older blind. Is there then no hope of raising the income levels of these persons?

The prospect offered by the Family Assistance Plan is the only recent proposal of broad significance. The Welfare Reform Act has three features affecting the aged blind:[3]

1. Establishment of a national minimum income of $130 per person per month for the adult categories, that is, for the needy aged, blind, or disabled;

2. Establishment of nationally uniform standards of eligibility; and

3. Separation of the administration of income maintenance from the provision of social services.

The minimum standard of need of $130 per month is slated to rise to $150 by 1974. This represents a substantial increase in the level paid under the present Aid to the Blind programs in 37 states. In Mississippi, for example, it would more than double the present average payment of $59.85 per month. In the remaining 17 states, the present level of payment could be maintained if each state picked up the full amount above $150 per month. Some states may do so because of the increased rate of financial participation by the federal government under the Welfare Reform proposal. In California and Nevada, for example, the present levels of $172 and $168 respectively could be maintained with no additional state outlay. The financing of the amounts above $150 would be more than offset by the savings accruing to the states from the 100 percent financing by the federal government of the costs up to $150. Indications are that responsibility for the administration of the adult categories may be placed with the Social Security Administration.

In summary, it is clear that the elderly blind are an especially poor subgroup of the aged -- a group that has, to begin with, the highest incidence of poverty of any segment of the population. The question of additional needs due to blindness probably requires no documentation. Yet such needs obviously go unmet because of income limitations. As one author noted,[4]

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[3] Coughlan, op. cit., p. 215

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[4] Kenneth Trouern-Trend, "Blindness in the United States," Travelers Research Center, Hartford, Conn (1968), p. 64.

In old age, and after retirement if they have been employed, blind persons usually have relatively few expenses which are additional to those of sighted persons. Considerably more could be spent on personal assistance, recreation and travel, but what frequently happens is that these and similar expenses are saved because the blind person lives a very restricted and unfortunate life, allowing a minimum of activity. This is frequently the result of lack of both personal assistance and the necessary financial resources.

THE PREVENTION OF BLINDNESS IN THE AGED

* Abraham L. Kornzweig, M.D., F.A.C.S.

Extent of the Problem

It has been estimated by the National Society for the Prevention of Blindness that for the year 1970, there were 437,000 cases of legal blindness in the United States. In the same year, 37,000 new cases were added. Close to 50 per cent of the blind are in the 65 years and older age group. Projected for the year 1977 by the same organization, the number of legally blind is estimated at 500,000 cases with about 39,000 new cases occurring during that year. The blindness incidence rate for that year in the 40 to 64 age group is estimated at 18 per 100,000, whereas for the 65 and over group, it is expected to be 94 per 100,000. The increase in blindness will continue to parallel the increase in total population.

Main Causes of Blindness in the Aged

The main causes of blindness and visual impairment in the aged are, in the order of frequency, senile cataract, diseases of the macula, glaucoma, diabetes as it affects the eye, and diseases of the blood vessels, so-called vascular diseases. Each one of these conditions will be discussed briefly from the point of view of prevention of blindness. Following such presentation, several proposals will then be made for immediate action in preventing or ameliorating the disastrous effects of blindness and near blindness in the aged population. Proposals will also be made for a long term attack on these problems from the point of view of education of the middle-aged and elderly population and continued support of basic scientific research.

Cataract

An ocular survey of over 1000 aged persons in a home for the aged, and another of 800 elderly people in private practice, showed an incidence of over 60 per cent with varying degrees of cataract formation. Indeed, it has been postulated that if one lives long enough, everyone will develop evidence of cataracts. Simply, a cataract is a clouding and opacification of the lens that is present in each eye directly behind the pupil. What causes cataract is not fully known. It is believed to be a result of the aging process in that the nourishment to the lens is diminished or changed sufficiently to affect its clearness and transparency. As this cloudiness becomes greater, vision is gradually

* Director of Department of Ophthalmology and Ophthalmic Research of the Jewish Home and Hospital for Aged of New York City.

impaired and partial or complete blindness will ensue. It can be prevented by the surgical removal of the cataractous lens. This operation has now been perfected to such a degree that it is successful in over 95 to 98 per cent of cases. Hence it should not be withheld from any elderly person regardless of age or physical disability. In fact, the rule now is, if a patient is ambulatory, has a cataract and wants the operation, it should be performed. A good many elderly people are aware of these facts and seek surgery for cure. But there still are many others who fear the operation or think they are too old or too feeble. Still others are handicapped economically, or are isolated in old age homes or poverty stricken areas of city or country. It is these individuals who should be reached and made aware of the possibilities for prevention of blindness from cataract formation.

Diseases of the Macula

In the ocular survey mentioned above, it was found that a large percentage of aged persons have varying degrees of diseases of the macula: 24 per cent of those under 80 years of age to 38 per cent in the over 80 age group. This condition causes a gradual loss of central vision, and visual acuity drops from 20/20 to 20/40 and eventually to 20/200. This is considered functional or legal blindness from any industrial viewpoint and qualification for an additional tax exemption.

The macula is a small area about 3/16 of an inch in diameter that is situated in the retina or inntermost lining of the back of the ye. It is responsible for the sharpness of central vision. It enables us to see clearly at great distances, so-called 20/20 vision, to read fine print, to sew fine stitches and to detect fine differences in color. It works best in daylight, hence it is called daylight vision. This is in contradistinction to peripheral or side vision, which enables us to see objects all around us without looking directly at them, and also enables us to see objects in diminished light, so-called night vision. Both types of vision are important to man. A person with macular disease is therefore not totally blind. He is still able to take care of himself and get around, even travel by himself. But he is not able to read a newspaper or a book, or enjoy television or movies or art objects, or identify people until they are very close, or use needle and thread. He is thus considerably handicapped at a time of life when there is more leisure to enjoy such activities.

The macular area of the eye in the aged is more vulnerable to disease than the rest of the retina. It can be affected by high blood pressure, kidney disease, blood vessel diseases and diabetes. It will also undergo deterioration, called senile macular degeneration, for reasons not too well understood. Some investigators believe that this type of macular disease may be hereditary. But in the aged other factors enter into consideration, such as arteriosclerosis, and the effects of lifetime exposure to light and heat, and other environmental conditions. It is known that undue exposure to a solar eclipse, or a welder's arc, will cause a burn in the macula that may permanently impair central vision. Certain infectious diseases such as histoplasmosis and toxoplasmosis can affect the macula. Excessive smoking and alcoholism will also affect central vision indirectly as a result of malnutrition and lack of vitamins, chiefly vitamin B complex.

Prevention of loss of central vision can be helped in thos cases which result from general diseases or infections by vigorous treatment of the underlying condition. For the rest, prevention and proper treatment can only come when we know more about the causes that lead to this disease. It is here that much more intensive and basic scientific research is necessary.

To help such patients to see and read better, many types of low vision aids have been devised. Most of these are magnifying glasses of varying strengths that enlarge the print sufficiently so that it can be read. Occasionally a special lens will enable a patient to see a numer on an approaching bus, or read a street sign or house number. For persons in whom an eye physician (ophthalmologist) has diagnosed disease resulting in impaired central vision, these lenses can sometimes be prescribed with benefit. Much more attention needs to be paid to low vision aids.

Glaucoma

Glaucoma is a condition that is now better understood by the general population, thanks to educational and screening programs carried out by private organizations and governmental agencies interested in prevention of blindness. Essentially, glaucoma is a disease that results when the internal pressure in the eye increases above a certain normal level. The average normal has been set by universal agreement at the ability to raise the level of a narrow column of mercury to 18 millimeters, as in a barometer. This normal level varies in individuals from 12 millimeters to 25 millimeters. Any continued elevation of the internal pressure above 25 mm. of mercury for an extended period of time will gradually compress nerve and capillary blood vessels until nutrition to the sensitive nerve fibers is gone, and loss of vision results. The effects of this loss of vision are first felt on peripheral vision, or side vision, and the field of vision becomes contracted and small, until all that is left is a cone of central vision which may be as low as 5^{o} in diameter, from the original 180^{o}. Eventually even this small area is snuffed out and total blindness ensures.

It has been estimated from several large screening projects involving many thousands of individuals that the percentage of glaucoma cases in the over 40 age population is between 1 1/2 to 3 per cent. This percentage increases from 5 to 10 per cent in the over 65 age group. Thus it is an important problem in the aged. This increase is due to many mechanical factors resulting from the aging process. But much more has to be known about this disease, and here also basic scientific research is needed.

More important, however, is that treatment for this condition has now improved to the point where much needless blindness can be prevented, if the patient is found in time. It is here that an eye examination by an ophthalmologist is so important in people over age 40, and especially in the elderly. In families where a parent or blood relative has glaucoma, the probability that the other members may get it is greater. There are tests which can determine which person may be a potential glaucoma case. Screening of large groups of people has been done across the country in order to detect the possible case. But a continuing process of education is necessary as more people approach the age of risk, over 40 years. Glaucoma may occur in persons under 40, especially in glaucoma suspect families.

Diabetic Retinopathy

In the last 10 or 15 years, there has been a marked increase in the number of aged persons with diabetes who suffer from failing vision leading to blindness. Ironically, this is the result of the better treatment now available to diabetic patients stemming from the discovery of insulin and the use of oral antidiabetic drugs. The patients live longer and are now showing the late complications of the disease. In the eye it shows itself by hemorrhages and the deposits of fatty substances called exudates. When the macula is affected central vision is impaired. If the hemorrhage fills the interior of the eyeball, vision is usually lost either temporarily but more often permanently. About half of the aged blind now suffer from this disease. It is a great challenge to the medical profession. Much study, research and experimentation is now concerned with this problem.

Can it be prevented? This is a fundamental question still unanswered. Good medical care of the diabetic patient is a prime necessity. Associated conditions that may be present such as high blood pressure and arteriosclerosis must also be treated by presently known drugs and low fat diets. The preferred treatment at present for the diabetic retinopathy, as the eye condition is called, is the use of photocoagulation by either the xenon arc or the ruby or argon laser beam. This method of treatment depends upon the effect of the light in sealing off visible bleeding points in the retina. In the early stage, this is effective; in the later stages it is much more problematical. This is a problem for immediate attention and possibly a crash program for research.

Vascular Conditions

Other vascular diseases that affect the eyes of the aged are those that cause a closure of an artery or vein. The main blood supply to the eye is by a single artery, and the return flow is through a single vein. Hence, any blood vessel disease that causes an obstruction in either the artery or vein is bound to affect vision in that eye, especially if the main vessel is involved. The blood vessels are affected by many conditions, chiefly high blood pressure, kidney disease, diabetes and arteriosclerosis. Prevention can only be effected by more intensive study and research into these fundamental conditions. Treatment at present is only partially successful. It must be stressed that when an eye is affected by a closure of a blood vessel, it should be considered an emergency and treatment by a physician sought as soon as possible. An eye deprived of its blood supply for over six hours will loose sight completely and will never regain it even if the circulation is reestablished. This is particularly true if the main artery is affected.

Accidents to the Eye

What may prove to be a major advance in prevention of accidents to the eye has been made by the recent ruling of the Food and Drug Administration that all eyeglasses be made of impact-resistant glass or plastic. This ruling goes into effect for the United States on January 1, 1972. It is interesting to note that the first state to pass such a law was Alaska and it was sponsored by an ophthalmologist who was a member of the state legislature at the time.

Continuing education of the general public on prevention of accidents to the yes is a necessity. This is especially true in industry where employees are exposed to rapidly moving machinery, excessive heat or light. For the aged in private homes, in nursing homes and in homes for the aged, special precautions are necessary to prevent accidents. Good lighting is important, as are night lights in bedrooms.

The Committee on Health of the White House Conference on Aging adopted the following policy: "Among the complex of health needs for the aged, priority should be given to the prevention and treatment of blindness." To implement this policy, the following proposals are now submitted for your approval, both for immediate action and for long term projects:

1) The problem of blindness due to diabetic retinopathy presents a challenge to medicine and should be given a high priority by government and the private sector. Exploration by the National Eye Institute with national professional societies is proposed for the urgent development of an overall program.

2) A good many elderly people are in homes for the aged and in nursing homes. It is proposed that an eye examination by an ophthalmologist should be part of the medical check up. The objective is to find all cases of blindness or near blindness that can be helped by medical or surgical means or by low vision optical aids. This may be done voluntarily by the private sector or implemented by legislative action.

3) The establishment of a center, preferably in the National Eye Institute, for study of diseases of the macula. Such a center will coordinate and support research in this condition, collect all available information, and disseminate research findings to all interested persons and the general public.

4) Increased support for research on such fundamental eye conditions as cataract, glaucoma and vascular diseases is proposed.

5) Physicians and concerned philantropic societies should consider establishing screening programs especially around hospitals and medical centers, to find the aged patients who might be sufferers from cataract, glaucoma or other eye diseases for which treatment is available to prevent blindness. Mobile units for outlying areas and needy urban sections may be of value.

6) Establishment of an educational center to disseminate knowledge of eye diseases that can be prevented. All methods of education can be used, including pamphlets, radio, television

and handbooks. Much material is presently available, but needs distribution to persons in the middle age and older age groups. All such persons especially the elderly should understand that what may appear to them to be an indication for a change in glasses may be a sign of serious eye disease. They should seek medical advice. Many eye conditions call for the combined services of the ophthalmologist, the internist, the neurologist and others as a medical team.

Such a program, properly planned and supported, should lead to a considerable reduction in the number of aged blind and near blind in the years ahead.

REHABILITATION SERVICES FOR THE OLDER BLIND PERSON

* Dr. Douglas C. MacFarland

I am greatly honored to participate with such a distinguished group of panelists this morning.

Rehabilitation service for the older blind person is a multi-faceted program. In order to keep within the time frame, I shall limit my remarks to the provision of social services leading toward independent living with some discussion of employment when this is desired and feasible. Some of what I shall say has been said before, but those who are vitally interested in developing a viable service program for the elderly blind will recognize that the suggestions are so essential they must be constantly brought to the attention of the public. This is imperative if we are to provide satisfactory solutions during the coming decade.

In spite of some significant successes, our provision of social services to blind persons is tragically inadequate. This is especially true for our older blind citizens, who constitute more than 50% of the total blind population. Perhaps the greatest obstacle to service delivery is a misunderstanding on the part of both the professional and the lay public. Too often they confuse a social need with the disability or treat both as inseparable.

It is comparatively easy to demonstrate special training needs or comprehensive rehabilitation services for a newly blinded person. These call for special techniques and professionally trained personnel that cannot be obtained from normal channels in a community. Most of the social needs of blind persons, however, are identical with those of their sighted peers, and it is a distinct disadvantage to blind persons to assume that they can or should be provided in a segregated environment.

Obviously, there are clearly identifiable services that require the skills of specially trained professional personnel. Most of the social needs, however, can be obtained from already existing community resources. In order to make use of these resources, we must have individuals who are capable of interpreting the problems of blindness to the general public.

The following few examples are meant to illustrate how this is already being implemented in many communities. A blind person may need special assistance in locating suitable housing. His need is not for a special segregated development for the blind. In fact, this arrangement might pose many problems that he would not other-

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* Director, Office for the Blind and Visually Handicapped, Rehabilitation Services Administration, SRS, U.S. Department HEW

encounter. His real need involves assistance in locating suitable convenient quarters in keeping with his financial status. It may also involve a factual explanation to building management that will allay any fears that he may not be a desirable or safe tenant. In spite of several validated studies, many home owners still believe that blind persons present unusual fire risks or that they are incapable of keeping the premises clean.

There are social areas where blindness definitely is the focal point and here the services of a specially trained person are vital; for example, counseling with a newly blinded person to make certain he is aware of all assistance available to achieve his maximum potential within the confines of his disability. Professional services are also required to counsel with members of the family, anticipating problems and helping with solutions. There is a great need for specialists in this area. The only way we can hope to overcome this shortage is by redirecting the focus of the private agency with a view toward purchasing the services when necessary.

The greatest problem we face today is that of providing social services for the older blind person. We have only begun to demonstrate in a few areas of the country how the social needs of this large group can be met. The services are relatively simple: Regular social visiting for the person living alone; reading mail and writing essential correspondence when necessary; accompanying the blind person on special shopping tours; orienting the blind person to immediate surroundings so that he can find restaurants, laundry, and other essential facilities; making certain that the person receives special training in home management if desired; and obtaining assistance to help the blind person make full use of recreational facilities that may be available to him. In order to implement these services to any degree that will have an appreciable impact on the total population that can profit from them, State and private agencies must recruit, train, and supervise vast numbers of volunteers. Models of such programs already exist, but these must be replicated on a much larger scale.

Studies in the early 60's which led to the introduction of a formalized university training program for mobility instructors clearly indicated that the vast majority of blind persons in the United States are unable to travel independently. While we have made some impact through the training of special mobility instructors and the development of comprehensive rehabilitation centers for the blind, it is still a fact that the majority of blind persons--due to age and other factors which have precluded them from vocational rehabilitation services--are unable to move about independently. Thus far, no one has developed an action program to deal with this pressing problem. If we use the current prevalence statistics available and measure these against the backdrop of our own experience in Social and Rehabilitation Service, it would seem conservative indeed to estimate that there are probably 100,000 blind persons in this country today who could profit from a modicum of travel instruction plus some training in activities of daily living. These services alone could

mean the difference between continuance in the family constellation and custodial care.

In order to be effective, the program should have a three-pronged attack. One, it should be designed to make the blind person as independent of the services of others as possible. No one can achieve self-fulfillment and self-satisfaction without this vital link in the chain. Two, the program should be aimed at freeing others in the constellation immediately surrounding the blind person for activities other than catering to the immediate needs of the blind person. In the family, this would mean that the person ordinarily assigned to stay home with the blind relative would be free to engage in other activities, including productive work. In hospital and nursing home settings, it would mean that service personnel assigned to fee and assist in activities of daily living of blind patients would no longer be needed for this work and, therefore, could be used to extend other vital services within the facility.

The third goal accruing from the provision of self-help and self-care services relates in part to point number two. In most nursing home facilities care for blind patients is considerably more expensive than for services rendered to non-blind patients in the same facility. The increased cost is based on the erroneous assumption that all blind patients will need to be led around, to be given intense assistance in coping with routine activities, and in the majority of cases to be fed by attendants. If all this were true, the additional charges would be justified. However, the few demonstration projects completed on this subject have conclusively proved that a proper training program designed to make the person independent of others in daily activities can be given in a very short period of time.

For reference, we would cite the research conducted by the Minneapolis Society for the Blind. The objective here was to close a segregated home for the blind and train the residents to get along in non-segregated environments. From the results presently available, it is obvious that the project has not only been a success from the standpoint of ability to train older blind persons in self-help and self-care, but the success is further enhanced by the positive attitude of blind residents, who now seem much happier in their new environment and new-found independence. There are many voluntary agencies similar to the Minneapolis Society for the Blind throughout the country that can provide the much-needed services, and wherever possible this would seem a desirable approach rather than attempting to expand professional staffs of the State agencies.

While it is obvious that much of the program outlined cannot become effective without a substantial amount of funding, I believe the program is entirely feasible and the mechanisms to make it work are already available. The real test of success or failure will rest, not on how well we are able to make use of funds for employment of staff for State or private agencies, but on whether we are able to take advantage of the vast amount of energy now available through proper and efficient use of volunteers

Thus far, agencies for the blind have demonstrated success in this area. They can justifiably boast that they are far ahead of most other social service agencies in this regard, and yet an honest appraisal of the situation -- viewed against the background of the great need -- would suffice to indicate that we have hardly scratched the surface. Recruitment, training, and supervision of volunteer workers will ultimately provide the answer to whether we are indeed able to offer a total program of services that will meet fundamental needs. Voluntary workers represent one of the greatest untapped sources of energy in this nation, and it is only through skillful use of this work force that we can do the many vast and complex jobs that must be done in so short a period of time. Work for the blind provides an excellent small experimental working area to test many of the theories which must be put into practice with respect to volunteer work if social services are to become a reality.

A small but important aspect of working with the geriatric blind is employment. Our culture is work-oriented, and in spite of automation I suspect it will remain so for a long time. Obviously, the older person with a severe visual loss will be limited in his ability to work. For the majority of these persons, work may be of no consequence. In planning our future programs, however, we must give serious consideration to developing employment opportunities that are feasible for those who wish to work and have the capability.

There are those who feel that an inordinate amount of money has been spent in preparing, training, and placing blind and visually limited persons in employment. I cannot share this view. The public and private money expended in this area has proved a prudent investment. I would concede, however, that far too little has been expended in dealing with the critical problems of those for whom employment is not a satisfactory objective.

During this decade a host of new jobs will be available to persons living in rural areas. Many of these will be practical opportunities, on a part-time or full-time basis, for the older visually limited person. Among these occupations are management and rental of lodging facilities, operating game and fishing-concessions, boat rental and repair, operating riding stables, bicycle rental facilities, and many others that may require some ingenuity for vocational rehabilitation counselors, but are entirely feasible if the client is interested and wishes to participate. Of course this is not the major solution for all older citizens with visual disabilities in rural areas, but it does provide opportunities for many who may wish part-time or full-time employment to supplement their incomes.

One proposal under consideration may provide a partial solution for the older blind and visually limited person living in the urban area: the development of unique workshops. Production would be geared specifically to the worker's needs. Work scheduling would be so designed that an employee might work for two hours a day, or

for whatever seemed practical for peak performance. Under these circumstances the worker could feel justified that he was making his contribution to society and earn a supplement to retirement benefits. We would suggest that this experiment take maximum advantage of the limited talent now available. The shop could be staffed with older supervisors and managers because persons drawn from this group would have a much better understanding of the problems facing the worker, and it is a well-established fact that effective managerial and supervisory talent is available among the retired.

As indicated at the outset, the ideas set forth in this discussion formulate a design for the future. They are presented here to elicit comments and suggestions that will give positive direction to colleagues. It is especially important to obtain your viewpoint since the success or failure of a program depends on the system of delivery that is adopted at the grass-roots level. You represent policy and program for consumers as well as the public and private agencies of the future, and we need your help in devising a sound program for the many thousands of blind persons that will receive services as a result of our current planning.

Of the many recommendations that could enhance the lot of the aged blind through improved rehabilitative services, I should like to submit three which may be added to others considered by the delegates. These are presented in an ascending order of importance.

1. That the Rehabilitation Services Administration be urged to develop special pilot demonstration programs designed to provide employment for older blind citizens in rural areas and that data be compiled so progress in this activity can be identified easily. The Rehabilitation Services Administration is further urged to fund the construction and staffing of at least one workshop designed exclusively for the employment of older blind workers. This shop could make use of contracts available under the Wagner-O'Day Act as well as those from private industry to determine the productive capacity of such workers and an estimate of the percentage of older blind persons who would be interested in employment activities.

2. That the Social and Rehabilitation Service Administration be urged to give high priority to the training of sufficient numbers of para-professional workers to make rehabilitation services available to all older blind persons within the next five years. Concurrent with the aforementioned activity, a study should be conducted of volunteer programs for the blind now in operation, and from these data guidelines should be constructed for the most effective program for recruitment, training, and supervision of volunteers. Minimum goals should be the doubling of the number of volunteers now engaged in the work with a greater emphasis on the number of hours worked

expanding services to the geriatric blind population.

3. The benefits of rehabilitation adjustment training, travel through the use of a dog guide or cane, instruction in activities of daily living, and other services designed to assist the blind person to compensate for the loss of sight, have been accepted as essential by all who are engaged in our field of work. Thus far, however, basic rehabilitation services have been restricted to blind persons being considered for employment. It has been conservatively estimated that at least 100,000 of older blind citizens who could reap rich dividends from such training seldom have an opportunity to participate because of the restrictive requirement of the Vocational Rehabilitation Act.

   In order to broaden this Act and make rehabilitation services universally available to blind persons of all ages, it is recommended that this conference communicate to Congress its support of S. 1030 and its companion bill, H. R.7949, designed to amend the Vocationalal Rehabilitation Act to include services to older blind Americans.

   This bill introduced by our keynote speaker, the Honorable Jennings Randolph, would provide modest sums to all State agencies serving the blind for offering the kinds of services I have been discussing. In addition, sums could be made available as necessary to support research demonstration and personnel training programs undertaken by public and private non-profit organizations. In my opinion this is the most important action that we can take to insure an effective program for those we wish to serve. With the Congressional support and a broadened legal base, the benefits of rehabilitation can be made available to all in this decade.

REALIZING A COMPREHENSIVE NATIONAL POLICY ON AGING AND BLINDNESS

* Robert Morris, D.S.W.

The concept of a comprehensive national policy on aging and blindness is a many-faceted, even a many splendored, thing. It is a call for a policy which will assure that the widest range of needs expressed by the aged and the blind be provided for by some combination of family, community, and governmental attention. The central thesis of these remarks is quite simple. Such a national policy has not been realized because attention has been diverted away from the more simple problems of living and surviving with a basic handicap.

A comprehensive approach involves attention to medical needs including prevention, rehabilitation in case of a disability, and that third neglected dimension of personal care to go on living day after day, month after month when the doctor and the rehabilitation expert have each completed their task.

Widespread evidence has been produced in many reports and studies, and in the background papers for this Conference, to the effect that those among the aged who are feeble, disabled, handicapped or otherwise limited in their personal capacity to perform all of the functions of daily life, face one of two alternatives once medical treatment or rehabilitation have been maximally realized. A predominant policy is to ease the way for such individuals into institutions, including proprietory nursing homes. Between 1963 and 1968, under present policies the number of persons living in such institutions increased by 46 percent. The alternative is to struggle against almost insurmountable obstacles to maintain a normal way of life in a normal community, without any help other than that provided sporadically by neighbors and family. The elderly who are blinded or visually limited share this difficulty along with the elderly who are handicapped for any other reasons and for many other conditions.

It is not at all unexpected that the subject of home help service, which I prefer to call a personal care service, is placed at the bottom of national policy attention following after the provision of income, medicine, rehabilitation, and the like. This is to be expected because a personal care service emphasizes less skilled activities and the homely activities which make it possible for the handicapped to continue to live in their own homes. It does not have attached to it as yet the glamour of dramatic treatment and recovery, following which all handicap disappears.

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* Robert Morris, D.S.W. - Director
Levinson Gerontological Policy Institute
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I want to propose a firm policy that will get as much attention and support to the problems of maintaining normal existence at home for the handicapped as is now given for medical treatment and for rehabilitation.

There are at least six million adults, half of them over 65, who are so severely disabled for physical reason alone, including visual handicap, that they are unable to perform the functions of daily living at home without some additional assistance which goes beyond the provision of income for food, clothing and shelter, and which exceeds the capacity or the interest of the medical professions.

In order to make a national policy truly effective and comprehensive, I would urge the following:

1. A national commitment of taxes to develop a network of personal care services throughout the country, whose major purpose is to assist the elderly blind, and all other handicapped persons, to maintain their own households for as long as they are capable of doing so. This network of personal care organizations provides those most varied personal care services; shopping services, escort help, home helps, minor home repairs, mobility assistance, transportation aides, food preparation where necessary, outreach to the isolated, etc.

2. This network of personal care services can be built upon the framework of existing agencies, be they visiting nurse associations, homemaker services, or the like. The personal care organization differs from these existing organizations in one major respect; they concentrate upon providing whatever personal care or home help services the disabled person requires, including the least-skilled as well as the most skilled services.

3. Personal care organizations (P.C.O.'s) will not come into being without firm financial foundations. I would call for national adoption of a personal care benefit to which handicapped or disabled persons become entitled when their disability for handling the affairs of daily life, for reasons of physical handicap, reaches an agreed-upon level. This level of disability could be set at 25 percent or 50 percent of normal capacity.

4. The personal care benefit can be administered as part of national health insurance program, as part of the Social Security program, or as a part of any other national activity including the adult programs of a reformed welfare system or a rehabilitation service.

5. The personal care benefit is payable to the entitled individual by reason of his condition and is not necessarily payable to a particular kind of agency offering a particular kind of service. The personal care benefit can be paid either by a voucher usable with an approved personal care providing agency, or can be in the form of a cash benefit as now prevails with the Veterans Administration, Workmen's Compensation in some states, and as now is provided through Social Security in some forty other countries of the world.

6. The personal care benefit, however, administered, should become payable to the provider organization on a pre-payment capitation basis, that is, the level of disability determines the size of the benefit which thus becomes an average of the amount considered necessary to complement the individual's capacity to manage his own affairs physically. This sum, when paid in advance to the personal care organization, permits the provider and the consumer to decide what type of service is more suitable to the individual's condition. The individualizing of a person's need and service is worked out between the consumer and the provider directly without any intermediary. The average benefit for a given level of disability should provide an incentive for providers to develop the most efficient and effective services without over-professionalization and without the over-use of highly skilled services which may not be necessary. At the same time, the average figure does make it possible for the provider organization to extend more skilled services in that smaller proportion of cases where that is necessary.

The call for a home help service or for a personal care service has been frequently raised in the past. It was mentioned in the 1961 White House Conference, and has been repeated for years before and after. The time has come for a clear national commitment to see that this necessary range of limited skill, yet necessary, services is developed with as much vigor as is now devoted to the development of medical services. A personal care benefit paid for a condition and not to a particular or predetermined service, handled through prepayment and capitation mechanisms using either cash or vouchers, promises to bring into being the requisite range of personal care services now lacking.

Failure to adopt this or some comparable program for the provision of personal care organizations would only mean extension of the present system in which: the handicapped and disabled are moved unnecessarily into nursing homes and other long-term institutions at high cost; medical care providers and medical care organizations are forced to devote a disproportionate amount of high-cost, high-skill manpower to take care of persons whose needs are more simple and home-based; the effective and efficient and economical operations of medical care and rehabilitation services will be handicapped and hampered; and a large proportion of the elderly blind will live under conditions which destroy a meaning capacity for self-care and force them prematurely into institutional care.

WHITE HOUSE CONFERENCE ON AGING, 1971

Session on Special Concerns

Aging and Blindness

RECOMMENDATIONS

Introduction

Since the American Foundation for the Blind participated actively in the 1961 White House Conference on Aging, we have a deep appreciation of its constructive impact in generating increased public awareness and concern for the unmet needs of our aging population and in stimulating a larger use of our nation's resources in meeting these needs.

We, in collaboration with other national, state and local organizations of and for the blind, do appreciate an opportunity to share with you our special concerns. As reported by the National Society for the prevention of Blindness, approximately half of the estimated 500,000 legally blind persons in the United States are 65 years of age or older while two thirds are past middle age. Moreover, the majority of all new cases of blindness each year fall within the same age bracket. Despite these facts, most of our efforts, in both the governmental and private sectors, have been directed to blind children and to blind adults of employable age. Only recently have we begun to consider the needs of the older blind person.

Another aspect of our special concern stems from our philosophical belief in the desirability of helping blind persons to achieve their fullest potential as integrated members of their community. While this belief in no way contradicts the need for specialized and often separate services for persons who are visually handicapped, there is an equal need to insure the availability of general community services. Within this context, our hope is that blind persons — in fact all handicapped individuals — will become beneficiaries of the rapidly expanding programs and services for older persons in such fields as health, nutrition, housing, recreation, employment, continuing education, etc. It often takes little if any adaptation to implement this concept, but unfortunately it rarely occurs automatically, i. e., without continuing interpreatation, education and planning.

In summary, we urge that the 1971 White House Conference give a high priority to the question of how handicapped persons, especially those who are visually handicapped, can be more effectively integrated and served by the ever-increasing number of special programs for older persons. As Senator Jennings Randolph of West Virginia stated in his keynote address to the Special Concerns Session on Aging and Blindness, "It is clear that we must change attitudes toward the blind. We must provide opportunities for normal living in society; not charity, but a chance. I fear that there is widespread misconception about the abilities and aspirations of elderly blind persons."

Our specific recommendations follow:

Recommendation

1. It is recommended that Congress increase old age, survivors and disability insurance and the adult public assistance categories to the intermediate level of living recommended by the Bureau of Labor Statistics (at least $2,297 for a single person and $4,185 for a married couple) and further that the adult categories of public assistance be federalized and that Social Security benefits not be deducted from public assistance payments.

Recommendation

2. It is recommended that the National Eye Institute and other interested organizations on a national and local level combine their efforts in an urgent overall program to prevent or alleviate diabetic retinopathy; establish a center for the study of diseases of the macula, and increase research efforts in the fields of cataract, glaucoma and vascular diseases of the eye; establish screening efforts especially at hospitals, medical centers, homes for the aged, nursing homes, and extended care facilities to find aged patients who have blinding eye diseases which can be helped by medical or surgical means and low vision aids. Such efforts should be made by interested philanthropic organizations and implemented if necessary by legislative action;

It is further recommended that the National Eye Institute be required to develop better statistics on incidence, prevalence and etiology of blinding eye conditions: that Congress amend Titles XVIII and XIX of the Social Security Act to cover low vision aids when the need is certified by an ophthalmologist or an optometrist specializing in low vision treatment; and that the number of low vision centers be increased and that the centers be staffed under the supervision of an opthalmologist or a qualified optometrist.

Recommendation

3. It is recommended that the Vocational Rehabilitation Act be broadened to make rehabilitation services available to blind persons without regard to age or economic need and that Congress be urged to enact S.1030, a bill to amend the Vocational Rehabilitation Act to provide rehabilitation services for older blind persons, and S.2506, a bill to amend the Randolph-Sheppard Act, to accomplish these purposes.

Recommendation

4. It is recommended that the elderly, including the blind and handicapped, must have access to all modes of mobility and transportation for obtaining the essentials of daily living and the cultural and social benefits of modern society.

Recommendation

5. It is recommended that the Administration and Congress develop a network of personal care benefits for individuals with a certain level of functional disability to enable the older person to purchase whatever services are necessary to help him remain in his own home if he so wishes; such benefit is to be in addition to basic minimum income and assure a financial basis for local community service providers.

1971 WHITE HOUSE CONFERENCE ON AGING

Special Concerns Session

Aging and Blindness

MINUTES

The Session convened at 8:10 a.m. on Wednesday, December 1, 1971.

Garson Meyer, Co-Chairman, National Task Force on Geriatric Blindness, presided and read a telegram from Dr. Peter J. Salmon, Trustee, American Foundation for the Blind, Inc., expressing his regrets at being unable to attend.

Dr. Wilfred D. David, Executive Director, National Society for the Prevention of Blindness, Inc., spoke briefly. He pointed to the great need for expansion of blindness prevention and treatment services for the aging.

Dr. Robert A. Resnik, Chief, Office of Program Planning, National Eye Institute, U.S. Department of Health, Education and Welfare, spoke of the necessity for research on causes of blindness incident to the aging process and called for a concentrated effort to reduce blindness from glaucoma through drugs, screening, etc. He pointed to research currently being done to treat cataracts medically as well as improvement of surgical removal techniques. He spoke of the following needs: an increase in the number of researchers, better public education and awareness of blinding eye diseases, and the clinical application of research findings.

The first major paper was presented by Dr. Douglas C. MacFarland, Director, Office for the Blind and Visually Handicapped, Rehabilitation Services Administration, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare. He told of the need for comprehensive social services leading to independent living, integration of the blind with the sighted population, counselling with newly blinded persons and their families, and for agencies to purchase services which are otherwise unavailable. There is also a need for better recreation opportunities for the blind person and for widespread mobility instruction.

He saw the goal of rehabilitation to be independence of the blind person, freeing other members of the family from the burden of constant care (or if the blind person is in a nursing home or extended care facility, freeing staff for other purposes) and also allowing blind persons to live, where necessary in nursing homes or other like facilities without having to pay for extra care. He looks for a move away from providing direct services through state agencies to more use of private agencies with which state agencies can contract for services. He also looks for an increased use of volunteers in the rehabilitation process and a specialized type of workshop where older blind persons could work on a part-time or occasional basis. Dr. MacFarland made the following recommendations:

1. RSA should be urged to develop demonstration programs to provide employment for older blind persons in rural areas and that the data so developed be widely circulated;
2. RSA should fund construction and staffing of at least one workshop

for older persons of the kind mentioned above; 3. SRS should give a high priority to training of paraprofessional workers to make rehabilitation services available to all older blind persons within the next five years and it should make a study of volunteer programs now in operation and develop guidelines for recruitment, training and supervision of volunteers. We should attempt to double the number of volunteers and increase the number of hours they work; 4. Rehabilitation adjustment training, mobility instruction, etc. are essential rehabilitation services but are unavailable to those who are not employable--these services should be made available to all persons who need or request them. S.1030 and H.R.7949, identical bills now pending in the Congress, would implement this recommendation. 5. There is also a continuing need for research and demonstration and training of professional personnel.

Following Dr. MacFarland's presentation, Senator Jennings Randolph (D-W.Va.) presented the keynote address. He spoke of the continuing need for treatment and prevention of blindness and of the need to provide older blind persons with rehabilitation services. In this connection he mentioned a bill he has introduced, S.1030, which provides such services without regard to ability of the rehabilitant to join the work force. The Senator further spoke of the necessity for more trained personnel and researchers in the area of rehabilitation.

In closing, Senator Randolph referred to another bill he has introduced which would expand employment opportunities for blind persons, including older blind persons, as operators of vending stands in Federal buildings. This bill, S.2506, is currently being strongly opposed by groups of federal employees who have been operating their own vending facilities in Federal buildings and using the income for employee's programs. Senator Randolph reiterated his support for providing every blind person who wishes, regardless of age, with some gainful employment land indicated that he will make every effort to seek legislation in furtherance of this purpose.

Following Senator Randolph's remarks, John Nagel, Chief, Washington Office of the National Federation of the Blind, one of the reactors, stated his strong support of the bills mentioned by the senator and his hope that the Session would formally adopt a resolution in support of S.1030, H.R.7949 (an identical bill in the House of Representatives), and S.2506, the Randolph-Sheppard Act Amendments of 1971.

Durward K. McDaniel, National Representative, American Council for the Blind, spoke of the need for provision of social services and vocational rehabilitation services to older blind persons as a matter of right without restrictions based on the age or financial ability of the applicant. In addition, Mr. McDaniel spoke in support of amending the Civil Rights Act of 1964 to prohibit discrimination against blind persons solely by reason of their blindness. He expressed the hope that the limitation of earnings for retired persons under Social Security would be eliminated or liberalized.

agencies so that a broader spectrum of employment possibilities might be considered for the blind as well as seeking to train a blind person for what he is suited for rather than what the agency thinks he should be suited for. Mr. Ranghel suggested that a committee be appointed to implement the recommendations of the session.

A delegate from the District of Columbia spoke of the need for a more adequate income and the need for training older blind persons to do something useful in order to keep them in the community rather than having them shut off from it.

A delegate from Los Angeles voiced concern about segregated housing for the blind and said she hoped we would make a recommendation against such housing.

A delegate from New York City mentioned the urgent need for adequate medical care personnel and more community workers and volunteers. This subject is being taken up by another group at the Conference.

The second major paper was presented by Dr. A. L. Kornzweig, Chairman, Liaison Committee, American Foundation for the Blind, Inc.-American Geriatrics Society, on the subject of Medicine and Health. Dr. Kornzweig spoke of several areas in which improvement is necessary. Among these were: increased use of low vision aids, periodic eye examinations for people over 40, glaucoma education and screening programs, more research on diabetic retinopathy, and prevention of accidents of the eye.

He made several concrete suggestions: 1. That diabetic retinopathy be given high priority in research both by the National Eye Institute and other research groups; 2. That there be periodic eye examinations in nursing homes and other homes for the aged in order to detect and treat preventable blindness; 3. That the National Eye Institute and others establish a research program on diseases of the macula; 4. That there be increased financial support for research on cataract, glaucoma, and vascular diseases which affect the eye; 5. That there be a community screening program, possibly using mobile units, to reach and treat aged patients who suffer from blinding eye diseases; 6. That there be an educational center established to disseminate information about preventable eye disease.

Comments were made from the floor by optometrists stating that their professional services should also be used in vision screening. Dr. Hellinger proposed that: the Medicare law be amended to pay for low vision aids when the need is certified by an ophthalmologist or optometrist specializing in low vision treatment; the number of low vision centers be increased; these centers be manned under the supervision of an ophthalmologist or qualified optometrist.

The next paper was presented by Dr. Robert Morris, Co-Chairman,

National Task Force on Geriatric Blindness. He outlined three needs of the elderly blind person: medical care and prevention, rehabilitation, and personal care and home help services. Dr. Morris called for the development of a nationwide network of personal care organizations to assist elderly persons to remain in their own homes as long as they desire to do so. These organizations should provide whatever services the clients request, even if it's a request for a simple non-skilled type of service.

These personal care services should be financed through Social Security and should be available to all those needing them as a matter of right. Purchase of services could be by voucher or by direct cash benefits and the amount of the benefit should be based on the severity of the handicap. We need to reallocate resources from provision of custodial care to provision of home care services.

The next speaker was Dr. Juanita M. Kreps, Professor of Economics and Dean, The Woman's College, Duke University, who spoke of the need for a guaranteed minimum income based on need with automatic increases based on increases in the cost of living. She also indicated that H.R.1, currently pending in the Senate Committee on Finance, will take a large step in this direction by federalizing the adult public assistance categories and establishing eventually a minimum of $150 per month. Thirty-seven states currently have public assistance payments below this level.

Another good feature of this bill is that it requires separation of income maintenance and provision of social services. Dr. Kreps recommended that OASDI and the adult public assistance categories (Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled) be increased to the intermediate level recommended by the Bureau of Labor Statistics ($2,297 for a single person over 65 and $4,185 for a married couple over 65) and that the public assistance categories be federalized and that Social Security benefits not be considered in determining eligibility for public assistance.

The final paper was presented by William C. Fitch, Executive Director, The National Council on The Aging, Inc., on transportation. He pointed out the urgent need for adequate transportation for the elderly and particularly the elderly blind. He recommended that the group adopt a resolution calling for the provision of adequate transportation services particularly to elderly blind and handicapped persons.

It was necessary to consolidate the ideas of the speakers into 5 recommendations, These were voted on by the delegates and approved for inclusion in the report of the White House Conference.

In floor discussion the following motion was made and adopted: That we recommend to Congress a nationally recognized identification card similar to a driver's license which blind persons could use for identi-

fication in the same manner in which sighted people now use a driver's license.

Also a suggestion was made, no action taken, that we support reduced fares on airplanes and municipal transportation for blind persons of all ages.

The meeting adjourned at 11:45 a.m. with a thank you to all the speakers, planners and participants.

MVW:hb

* DELEGATES

SPECIAL CONCERNS SESSION ON AGING AND BLINDNESS

Name	State
Jacob Cohen, O.D.	Pennsylvania
Honorable Tom Dougherty	Iowa
Vincent A. Riccio	New York
Frederick C. Swartz, M.D.	Michigan
George E. Johnson	Maryland
Mrs. Gheodore R. McKelden,Jr.	Maryland
Marjorie T. Borchardt	California
Bertne Weist	Ohio
Wm. Lolsten	Connecticut
Florence Fox	Florida
Mr. Laurence Howbert	Florida
Julius V. Miller	Mississippi
Wilfred D. David, M.D.	New York
Alfred D. Teunis	D. C.
Dr. Frank Brazelton	California
Mr. Jerome A. Miller	D. C.
Mrs. Bessie Moses	Alaska
Douglas W. Redmond	D. C.
Mrs. Alice L. Smith	Nevada
Milton Klein	Ohio
Abraham L. Kornzweig, M.D.	New York
Dr. Donald C. Exford	Massachusetts
Edward V. Driscoll	Massachusetts
Garson Meyer	New York
Mrs. Effie Roebuck	D. C.
Dr. Robert L. Wright	Georgia
Miss Dianne Yasui	Hawaii
Mary Fortier	Maine
Mrs. Effie Pentz	Montana
Peter J. Salmon	New York
Frederick Picard, III	Massachusetts
Mr. J. Kenneth Cozier	Ohio
Miss Marion V. Wurster	New York
Mrs. A.M.G. Russell	California
Mr. F. Marott Sinex	Massachusetts
Dorothy Demby	New York
Charles Alvarez	New York
Ruth Lana	California
Foo Lin Ching	Hawaii
Erich Helbig	Tennessee

*Includes partial listing of delegates in attendance, as well as guests.

E. Dailey	Albany, New York
Frances Conn	Washington, D. C.
Adeline Franzel	Trenton, N.J.
Cleo Dolan	Chicago, Ill.
Robert L. Robinson	New York
Mrs. Billie Elder	Calif.
Durward K. McDaniel	Washington, D. C.
Lillian Reenes	New York City
Sally Baitty	Clarksburg, West Va.
Jo Ellen Jennette	Washington, D. C.
Audrey Kech	New York City
William Edwards	Washington, D. C.
Aparicio G. Ranghel	Washington, D. C.
Edina Frick	Detroit, Mich.
Betty John	
Rev. L. P. Phillips	Texas
Seymour Hassett	Washington, D. C.
William B. Hix	Chicago, Ill.
Mrs. Robert Morris	Waltham, Mass.
John C. Gaskiller	Washington, D. C.
Mrs. A. L. Kornzweig	New York City
Robert A. Resnik, Ph. D.	Bethesda, Md.
Mrs. Rosa Speckel	Bethesda, Md.
Ruth Kaarlela	Kalamazoo, Mich.
Robert Morris, D.S.W.	Waltham, Mass.
George O. Hellinger, O.D.	New York City
Lanius, Peggy	Atlanta, Ga.
Martin J. McNamara	Washington, D. C.
L. H. Autry	Arkansas
Howard H. Hanson	Pierre, South Dakota
Herb Brown	Lowdonville, N. Y.
John Gaskill	Washington, D. C.
Gerard deAngelis	Washington, D. C.
Harry R. Dunham	New Bedford, Mass.
Mrs. Elizabeth Farquhar	Washington, D. C.
Miss Marion V. Wurster	New York City
Nathan Kahn	New York City
Daniel M. Meyers	Rochester, New York
Eleanor K. Dailey	Albany, New York
Mrs. Frances T. Dover	New York City
Miss Elizabeth Straup	Washington, D. C.
John F. Nagle	Washington, D. C.
Irvin P. Schloss	Washington, D. C.
Senator Jennings Randolph	Washington, D. C.
Dr. Juanita M. Kreps	Durham, North Carolina
Dr. Douglas MacFarland	Washington, D. C.
William C. Fitch	Washington, D. C.

White House Conference on Aging 1971

WASHINGTON, D.C. 20201
(202) 386-6234

Dr. A. L. Kornsweig
Chairman, Planning Committee
American Foundation for
the Blind, Inc.
15 West 16th Street
New York, New York 10011

Dear Dr. Kornsweig:

I want to thank you personally for your contribution to the Special Concerns Session on Aging and Blindness. The proposals made by the Session are very important and I shall do my very best to see to it that they receive the consideration they deserve.

I hope that I may continue to call upon you for further assistance as we move ahead to action in the ensuing year.

Very Sincerely and cordially yours,

Arthur S. Flemming
Chairman

WESTERN UNION

11/29/71

Miss Dorothy Demby
American Foundation for the Blind
% Washington Hilton Hotel
1919 Connecticut Avenue, N.W.
Washington, D. C.

Friends of Older Blind Persons:

I am indeed sorry not to be with you in person today but Mrs. Salmon is ill. Maybe this points up the necessity for action in behalf of those in the older age group and both Lilyan and I are in this category.

In these brief few hours that you have to work together this morning, I think you will be saddened, educated and inspired. Saddened because so little has been done for older blind persons, educated because of the efforts of such groups as the American Association for Retired Persons, the Senate and House Committees on Aging and, in our own field, the American Foundation for the Blind, through its Task Force and the accomplishments of the Staff the problems of older blind persons.

I hope you will be inspired by the recommendations and action of this Conference this morning, particularly if there is prompt follow up. The hour is late for many older blind persons who will never receive the benefit of the services they need. It is not too late for other older blind persons, a group which is increasing percentage-wise all the time

As a trustee of the American Foundation for the Blind I greet you and extend best wishes from AFB and my own personal warm greetings and high respect. May your deliberation be fruitful.

Dr. Peter J. Salmon
Board of Trustees
American Foundation for the Blind

SPECIAL CONCERNS SESSION - AGING AND BLINDNESS

Planning Committee

Dr. A. L. Kornzweig, Chairman

Dr. Wilfred D. David

Mr. Garson Meyer

Dr. Robert Morris

Miss Dorothy Demby

Mr. Harold G. Roberts

Miss Marion V. Wurster

Mr. Robert Robinson

Mr. Irvin P. Schloss

Committee on Arrangements

Mrs. Elizabeth Parquhar

Miss Marion V. Wurster

Mr. Nathan Kahn

Mr. Daniel M. Meyers

Miss Eleanor K. Dailey

Miss Ruth Kaarlela

Mrs. Frances T. Dover

Miss Elizabeth Straup

Mr. Gerard deAngelis

Miss Dorothy Demby
Staff Associate
National Task Force on Geriatric Blindness